defence only if the junior doctor had sought the advice and help of his superiors when he did or might have needed it.

It seems to me that the doctor spending his first fortnight or so in a new specialty will be routinely supervised in everything he does by the conscientious consultant; the more experienced junior in a specialty will know when he is out of his depth. In between those two stages there is always a period of time when the junior doctor may have gained enough confidence to handle the more common problems but insufficient experience to recognise that he is missing something important or mishandling something vital. It is at this point that skill is required on the part of the supervisor, and I would be interested to know if there have been any legal judgments that hinged on the degree of supervision that had been offered to the inexperienced junior.

It seems a shame to me that the law seems to put the onus on the junior doctor for deciding when he is outside the limits of his own experience, knowledge, and confidence. Surely the consultant body must bear an equal responsibility for determining that supervision is realistic to each individual case. We should be prepared to be vulnerable to charges of negligence if we fail to be available to our junior colleagues for any matter on which they lack confidence, however trivial it may seem to us.

K C JUDKINS

East Grinstead,
Sussex RH19 3DZ

AUTHOR'S REPLY,—I know of no cases in which a consultant's alleged negligence has hinged on the degree of supervision offered to a junior, but certainly a consultant could be held liable if he failed to supervise adequately or delegated to a junior a task that was beyond his powers. I am not sure that the law does put the onus on the junior doctor to decide where the limits of his competence lie. The Wilsher case makes it clear that the standard of care expected of a junior doctor is that of the reasonably competent doctor at that particular level of training and in that post. If the evidence shows that such a doctor, in the circumstances of the particuar case, would also not have realised that a particular task was outside his competence then the junior doctor should not be held liable. The consultant, however, could be liable if the evidence shows that his level of supervision fell below the standard expected of a reasonably competent consultant. The health authority could also be held directly liable if it allocates juniors to duties beyond their competence or fails to provide for adequate supervision.

The law does recognise that the junior doctor may not have enough experience to know his limits. One of the judges in the Wilsher case, Sir Nicolas Browne-Wilkinson, the Vice Chancellor, referred specifically to this problem: "The young houseman or the doctor seeking to obtain specialist skill in a special unit . . . would be negligent if he undertook treatment for which he knows he lacks the necessary experience and skill. But one of the chief hazards of inexperience is that one does not always know the risks which exist. In my judgment, so long as the English law rests liability on personal fault, a doctor who has properly accepted a post in a hospital in order to gain necessary experience should only be held liable for acts or omissions which a careful doctor with his qualifications and experience would not have done or omitted." His lordship acknowledged that this would be unsatisfactory because a patient's rights would then depend on the experience of the doctor who treats him. The solution is to allege negligence against the health authority directly rather than just vicariously as employer of the doctor, as has been the practice. "In my judgment a health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient."

CLARE DYER

London NW1

Political dissent and "sluggish" schizophrenia in the Soviet Union

SIR,—Undoubtedly, international professional inquiry and collaborative research are useful in unravelling psychiatric truths, as Dr G Wilkinson suggests in his leading article (13 September, p 641), but he has reached his conclusions by stating that at least two aspects of the ethical dilemmas involved in holding people in psychiatric establishments in the Soviet Union are "clear" when they are far from clear. He has left unresolved the main problem of how British doctors should respond to claims of several of their Soviet colleagues that Soviet psychiatry is being abused contrary to Soviet law, Soviet medical ethics, and the spirit of international opinion as witnessed by the Helsinki agreement.

Dr Wilkinson suggests that the misuse of psychiatry in the USSR has historical precedent in imperial Russia. It is important that tsarist excesses are not ignored, but they were, at the most, occasional; there was no question of abuses being systematic or directed by state policy. Indeed, in 1911 Professor Serbsky—the institute founded in his name is now unequivocally linked with political repression in the USSR—was outspoken in condemning unjust social and economic conditions in Russian society, which, he suggested, were at the root of mental illness. In contrast, our contemporary Soviet colleagues are limited in those criticisms that they may offer of their society because at their graduation they swore an oath: "In all my actions I will be guided by the principles of communist morality. . . ." It is by manipulation of the fact that a psychiatrist's allegiance is firstly to the state and only secondarily to individuals that the NKVD (the predecessor of the KGB) established in the late 1930s the first psychiatric hospital with a special section for "politicals." The psychiatrist Dr Anatoly Koryagin was himself a victim of this Soviet code when in 1981 the *Lancet* published his evidence of unethical and illegal detention of "sane" people.[1] He is now serving a recently lengthened sentence of 14 years for "anti-Soviet agitation and propaganda." The most recent news from the USSR suggests that he is gravely ill after prolonged torture.

Secondly, Dr Wilkinson suggests that as there is controversy about Soviet psychiatric practices the answer lies in research and subsequent enlightenment. In psychiatry there may, in certain cases, be justification for the use of certain presently ill defined diagnoses such as sluggish schizophrenia, and this place may one day be better recognised. It is surely wrong, however, to suggest that there is any justification in these diagnoses being meted out to many dozens of individuals in the USSR. Both psychiatrists and lay people in the USSR have described in detail many of these cases, in which there is no question that both Soviet law and Soviet psychiatric procedures have not been followed in order to give political expediency precedence over legal and ethical positions.

Political dissenters held in psychiatric prisons have consistently believed that their only hope of salvation has rested with the unambiguous condemnation of their detention by medical opinion in the free world. To that end, in 1971 Vladimir Bukovsky compiled comprehensive data on the abuse of psychiatry in the USSR. It took 13 years before medical opinion world wide could be sufficiently galvanised to confront the USSR, but the USSR resigned from the World Psychiatric Association to avoid discussion of the issues.

Dr Wilkinson fails to speak out and state that although sluggish schizophrenia may be a potentially useful diagnosis, in the case of hundreds of people given this diagnostic label the probability of its being the true cause of their detention is negligible. He appears to be suggesting that the medical profession should be proud of its record of relative inactivity, despite the ready availability of reliable information on the political abuse of psychiatry in the USSR, and that, essentially, even greater inactivity is the way forward. Do not dissidents held in psychiatric establishments in the USSR deserve somewhat more effort than that from the medical profession world wide? Complacency by the medical profession to the degree suggested by Dr Wilkinson would be iniquitous.

H J N ANDREYEV

The London Hospital Medical College,
London E1

1 Koryagin A. Unwilling patients. *Lancet* 1981;i:821-4.

Drug points

Desmopressin and hyponatraemia

Dr G D O LOWE (Regional Haemophilia Reference Centre, Royal Infirmary, Glasgow G31 2ER) writes: Dr Christopher J Mathias and colleagues (9 August, p 353) observed that one of their six patients with progressive autonomic failure developed symptomatic hyponatraemia after repeated intramuscular injection of the antidiuretic agent desmopressin. Parenteral desmopressin is most commonly used for treatment or prophylaxis of bleeding in patients with mild haemophilia A or von Willebrand's disease, since intravenous infusion increases plasma concentrations of the factor VIII/Willebrand factor complex.[1-4] Shortly after the original report of such treatment[1] we reported symptomatic hyponatraemia after intravenous desmopressin, which responded to water restriction.[2] While subsequent experience has shown that desmopressin is an extremely useful treatment for several bleeding disorders, and that this complication is uncommon,[3] a further report of grand mal seizure associated with hyponatraemia (121 mmol/l) after four doses of desmopressin in a patient with von Willebrand's disease has recently appeared,[4] and I am aware of one other unpublished case. Dr Mathias and others report a fourth.

While the incidence of water intoxication complicating parenteral desmopressin therapy remains to be defined by further studies, it is now an established adverse effect and hardly a surprising one. I suggest that all patients receiving more than one parenteral dose of desmopressin in a course of treatment should have a daily clinical assessment for water toxicity and serum sodium estimations: if hyponatraemia or water intoxication occurs treatment should be stopped and water intake restricted.

1 Mannucci PM, Ruggeri ZM, Pareti FI, Capitanio A. 1-Deamino-8-D-arginine vasopressin: a new pharmacological approach to the management of haemophilia and von Willebrands disease, *Lancet* 1977;i:869-72.
2 Lowe G, Pettigrew A, Middleton S, Forbes CD, Prentice CRM. DDAVP in haemophilia. *Lancet* 1977;ii:614-5.
3 Mannucci PM. Hemophilia diagnosis and management: progress and problems. In: Poller L, ed. *Recent advances in blood coagulation*. Vol 3. Edinburgh: Churchill Livingstone, 1981: 193-210.
4 de la Fuente B, Kasper CK, Rickels FR, Hoyer LW. Response of patients with mild and moderate hemophilia A and von Willebrand's disease to treatment with desmopressin. *Ann Intern Med* 1985;103:6-14.

Adverse skin reaction to midazolam

Drs C G MORAN and G P GRAHAM (Department of Orthopaedics, Cardiff Royal Infirmary, Cardiff CF2 1SZ) write: Midazolam is an effective agent for